

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042796

Facility Name: ASTA CARE CENTER OF TOLUCA

Address: 101 EAST VIA GHIGLIERI TOLUCA 61369
Number City Zip Code

County: MARSHALL

Telephone Number: (815) 452-2367 Fax # (815) 452-2947

IDPA ID Number: 36-4163264

Date of Initial License for Current Owners: 07/01/97

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) MICHAEL GILLMAN
(Title) PRESIDENT

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date) _____
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

0042796 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>71</u>	Skilled (SNF)	<u>71</u>	<u>25,915</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>33</u>	Intermediate (ICF)	<u>33</u>	<u>12,045</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>104</u>	TOTALS	<u>104</u>	<u>37,960</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,425</u>	<u>1,425</u>	8
9	SNF/PED					9
10	ICF	<u>20,923</u>	<u>4,433</u>		<u>25,356</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,923</u>	<u>4,433</u>	<u>1,425</u>	<u>26,781</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.55%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 07/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/01/97 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 8 and days of care provided 1,425

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	205,856	13,125	6,733	225,714		225,714	0	225,714			1
2	Food Purchase		126,322		126,322		126,322	(3,397)	122,925			2
3	Housekeeping	131,201	11,369	0	142,570		142,570	0	142,570			3
4	Laundry	45,030	11,087	619	56,736		56,736	0	56,736			4
5	Heat and Other Utilities			73,345	73,345		73,345	0	73,345			5
6	Maintenance	50,741	19,878	16,383	87,002		87,002	3,324	90,326			6
7	Other (specify):*			3,442	3,442		3,442	0	3,442			7
8	TOTAL General Services	432,828	181,781	100,522	715,131	0	715,131	(73)	715,058			8
	B. Health Care and Programs											
9	Medical Director	0		7,200	7,200		7,200	0	7,200			9
10	Nursing and Medical Records	782,590	50,965	9,200	842,755		842,755	0	842,755			10
10a	Therapy	0		944	944		944	0	944			10a
11	Activities	49,088	6,248	1,023	56,359		56,359	0	56,359			11
12	Social Services	17,479	2,474	5,174	25,127		25,127	0	25,127			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	849,157	59,687	23,541	932,385	0	932,385	0	932,385			16
	C. General Administration											
17	Administrative	52,124		180,407	232,531	(8,700)	223,831	(145,752)	78,079			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			16,144	16,144	8,700	24,844	4,265	29,109			19
20	Dues, Fees, Subscriptions & Promotions			33,517	33,517		33,517	(22,502)	11,015			20
21	Clerical & General Office Expenses	79,434	2,623	28,383	110,440		110,440	60,523	170,963			21
22	Employee Benefits & Payroll Taxes			242,474	242,474		242,474	0	242,474			22
23	Inservice Training & Education			4,318	4,318		4,318	0	4,318			23
24	Travel and Seminar			0	0		0	52	52			24
25	Other Admin. Staff Transportation			4,742	4,742		4,742	4,432	9,174			25
26	Insurance-Prop.Liab.Malpractice			47,321	47,321		47,321	2,740	50,061			26
27	Other (specify):*			18,739	18,739		18,739	(10,581)	8,158			27
28	TOTAL General Administration	131,558	2,623	576,045	710,226	0	710,226	(106,823)	603,403			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,413,543	244,091	700,108	2,357,742	0	2,357,742	(106,896)	2,250,846			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			30,920	30,920		30,920	(7,198)	23,722			30
31	Amortization of Pre-Op. & Org.			1,718	1,718		1,718	0	1,718			31
32	Interest			11,580	11,580		11,580	21	11,601			32
33	Real Estate Taxes			14,702	14,702		14,702	0	14,702			33
34	Rent-Facility & Grounds			375,089	375,089		375,089	0	375,089			34
35	Rent-Equipment & Vehicles			15,328	15,328		15,328	704	16,032			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			449,337	449,337	0	449,337	(6,473)	442,864			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			122,026	122,026		122,026	0	122,026			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			56,940	56,940		56,940	0	56,940			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	178,966	178,966	0	178,966	0	178,966			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,413,543	244,091	1,328,411	2,986,045	0	2,986,045	(113,369)	2,872,676			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,696)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(872)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,525)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(650)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,739)	27		24
25	Fund Raising, Advertising and Promotional	(22,116)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	3,324			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,274)		\$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(61,095)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (61,095)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (113,369)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	<u>Gift and Coffee Shops</u>					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 3324	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	3,324		49

Summary A

12/31/2001

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MICHAEL GILLMAN	50	LIST ATTACHED		ASTA HEALTH-CARE COMPANY	ELGIN	MANAGEMENT
DENIS RUBEN	50					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 171,707			\$	(171,707)	1
2	V				ASTA HEALTHCARE COMPANY, INC.				2
3	V	17	OFFICER SLARIES				25,955	25,955	3
4	V	19	PROFESSIONAL FEES				4,265	4,265	4
5	V	20	DUES,FEES,SUBSCRIPTIONS				264	264	5
6	V	21	OFFICE EXPENSES				60,523	60,523	6
7	V	27	EMPLOYEE BENEFITS				8,158	8,158	7
8	V	24	EDUCATION & SEMINAR				52	52	8
9	V	25	TRANSPORTATION STAFF				4,432	4,432	9
10	V	26	INSURANCE GENERAL				2,740	2,740	10
11	V	30	DEPRECIATION				3,498	3,498	11
12	V	32	INTEREST EXPENSE				21	21	12
13	V	35	EQUIPMENT RENT				704	704	13
14	Total			\$ 171,707			\$ 110,612	\$ * (61,095)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3		LIST ATTACHED									3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA # 0042796 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization ASTA HEALTHCARE COMPANY
Street Address 134 N. MCLEAN BLVD.
City / State / Zip Code ELGIN, IL 60123
Phone Number (847) 742-8822
Fax Number (847) 742-9013

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SLARIES	PATIENT DAYS	154,774	5	\$ 150,000	\$ 150,000	26,781	\$ 25,955	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	154,774	5	24,648		26,781	4,265	2
3	20	DUES,FEES,SUBSCRIPTIONS	PATIENT DAYS	154,774	5	1,525		26,781	264	3
4	21	OFFICE EXPENSES	PATIENT DAYS	154,774	5	349,775	319,993	26,781	60,523	4
5	27	EMPLOYEE BENEFITS	PATIENT DAYS	154,774	5	47,148		26,781	8,158	5
6	24	EDUCATION & SEMINAR	PATIENT DAYS	154,774	5	300		26,781	52	6
7	25	TRANSPORTATION STAFF	PATIENT DAYS	154,774	5	25,616		26,781	4,432	7
8	26	INSURANCE GENERAL	PATIENT DAYS	154,774	5	15,832		26,781	2,740	8
9	30	DEPRECIATION	PATIENT DAYS	154,774	5	20,218		26,781	3,498	9
10	32	INTEREST EXPENSE	PATIENT DAYS	154,774	5	124		26,781	21	10
11	35	EQUIPMENT RENT	PATIENT DAYS	154,774	5	4,066		26,781	704	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 639,252	\$ 469,993		\$ 110,612	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$		\$			\$							1
2																			2
3																			3
4																			4
5																			5
	Working Capital																		
6	RELATED PARTY		X															21	6
7	INSURANCE POLICIES		X	INSURANCE POLICIES														1,580	7
8	ASTA ROCKFORD LLC	X		WORKING CAPITAL														10,000	8
9	TOTAL Facility Related						\$	0	\$	0				\$	11,601			9	
	B. Non-Facility Related*																		
10	IRS, IDR, ETC																		10
11																			11
12																			12
13																			13
14	TOTAL Non-Facility Related						\$	0	\$	0				\$	0			14	
15	TOTALS (line 9+line14)						\$	0	\$	0				\$	11,601			15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.				\$	<u>12,200</u> 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	<u>13,451</u> 2
3. Under or (over) accrual (line 2 minus line 1).				\$	<u>1,251</u> 3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<u>13,451</u> 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<u>14,702</u> 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996	<u>0</u>	8	
		1997	<u>0</u>	9	
		1998	<u>11,683</u>	10	
		1999	<u>12,200</u>	11	
		2000	<u>13,451</u>	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL					
THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.					

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF TOLUCA COUNTY MARSHALL

FACILITY IDPH LICENSE NUMBER 0042796

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	14-05-206-001	NURSING HOME	\$ 13,451.02	\$ 13,451.02
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 13,451.02	\$ 13,451.02

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 0 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1					\$	1	
2						2	
3	TOTALS				\$ 0	3	

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGN		1997		950	24	39	24		101	9
10	WATER HEATER		1997		2,824	73	39	73		307	10
11	NURSES STATION		1998		6,622	170	39	170		531	11
12	ELECTRICAL WATER HEATER		1998		3,400	87	39	87		272	12
13	HANDRAILS		1998		4,445	114	39	114		356	13
14	LAUNDRY BUILDING		1999		69,014	2,510	27.5	2,510		5,752	14
15	DOORS		2000		3,400	124	27.5	124		191	15
16	REKEY LOCKS		2000		1,672	61	27.5	61		94	16
17	DOORS		2000		10,080	366	27.5	366		565	17
18	BUSHES		2000		2,493	166	15	166		256	18
19	ROOF		2000		16,511	600	27.5	600		925	19
20	FENCE		2000		2,981	199	15	199		307	20
21	FURNISHING		2000		2,271	556	7	556		881	21
22	ROOF		2001		6,500	128	27.5	128		128	22
23	DOOR ACCESS SYSTEM		2001		2,825	56	27.5	56		56	23
24	FLASHING		2001		1,250	25	27.5	25		25	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 137,238	\$ 5,259		\$ 5,259	\$ 0	\$ 10,747	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 124,619	\$ 20,654	\$ 12,462	\$ (8,192)	10 YRS	\$ 34,567	71
72	Current Year Purchases	25,033	5,007	2,503	(2,504)	10 YRS	2,503	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY		3,498	3,498	0			74
75	TOTALS	\$ 149,652	\$ 29,159	\$ 18,463	\$ (10,696)		\$ 37,070	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 286,890	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,418	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,722	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,696)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 47,817	85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MONTE CASINO HEALTHCARE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		104	07/97	\$ 375,089	30		3
4	Additions							4
5								5
6								6
7	TOTAL		104		\$ 375,089			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☒ YES ☐ NO Terms: PURCHASE PRICE 3796000 *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 15,328 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning 07/97
Ending 07/27

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	\$ 384,605
13.	12/31/2003	\$ 394,121
14.	12/31/2004	\$ 404,430

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES
☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$		\$	0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 28,552	\$		\$ 28,552	1
2	Licensed Speech and Language Development Therapist		hrs			832			832	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			39,449			39,449	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				34,540		34,540	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					385	18,268		18,653	13
14	TOTAL			\$		\$ 69,218	\$ 52,808		\$ 122,026	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,085	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	455,094		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,807		6
7	Other Prepaid Expenses	751		7
8	Accounts Receivable (owners or related parties)	2,925		8
9	Other(specify): REAL ESTATE TAX ESCROW	10,806		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 480,468	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	134,967		15
16	Equipment, at Historical Cost	170,944		16
17	Accumulated Depreciation (book methods)	(109,801)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,606		19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs	(2,344)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 196,372	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 676,840	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 129,762	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	39,463		30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	4,975		31
32	Accrued Real Estate Taxes(Sch.IX-B)	13,451		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO MASTER ACCOUNT</u>	285,600		36
37	<u>EMPLOYEE LOANS ADV WAGE</u>	212		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 473,463	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>MEMBERS LOANS</u>	140,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 140,000	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 613,463	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 63,377	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 676,840	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 211,101	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 211,099	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(147,722)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (147,722)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 63,377	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,793,653	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,793,653	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	39,041	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 39,041	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	209	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 209	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PURCHASES DISCOUNTS	872	28
28a	ADJ PRIOR YR ADJ	4,958	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,830	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,838,734	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	715,131	31
32	Health Care	932,385	32
33	General Administration	710,226	33
	B. Capital Expense		
34	Ownership	449,337	34
	C. Ancillary Expense		
35	Special Cost Centers	122,026	35
36	Provider Participation Fee	56,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,986,045	40
41	Income before Income Taxes (line 30 minus line 40)**	(147,311)	41
42	Income Taxes	(411)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (147,722)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,149	2,356	\$ 48,899	\$ 20.76	1
2	Assistant Director of Nursing	2,065	2,443	44,131	18.06	2
3	Registered Nurses	13,399	14,544	229,221	15.76	3
4	Licensed Practical Nurses	3,531	4,091	54,799	13.40	4
5	Nurse Aides & Orderlies	38,283	42,196	389,198	9.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,105	1,388	13,200	9.51	9
10	Activity Assistants	4,212	4,767	35,888	7.53	10
11	Social Service Workers	1,665	1,742	17,479	10.03	11
12	Dietician					12
13	Food Service Supervisor	1,951	2,086	27,027	12.96	13
14	Head Cook	8,323	9,371	80,146	8.55	14
15	Cook Helpers/Assistants	10,500	12,013	98,683	8.21	15
16	Dishwashers					16
17	Maintenance Workers	4,351	4,799	50,741	10.57	17
18	Housekeepers	15,056	16,270	131,201	8.06	18
19	Laundry	6,005	6,241	45,030	7.22	19
20	Administrator	1,946	2,200	52,124	23.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,382	7,997	79,434	9.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,858	2,034	16,342	8.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,781	136,538	\$ 1,413,543 *	\$ 10.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	\$ 5,565	1-3	35
36	Medical Director	MONTHLY	7,200	9-3	36
37	Medical Records Consultant	MONTHLY	640	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	936	10-3	39
40	Physical Therapy Consultant		944	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	MONTHLY	1,023	11-3	44
45	Social Service Consultant	MONTHLY	5,174	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,482		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
JANICE KINDRED	ADMIN	0	\$ 52,124	Workers' Compensation Insurance	\$	29,820	IDPH License Fee	\$
			0	Unemployment Compensation Insurance		9,008	Advertising: Employee Recruitment	2,022
				FICA Taxes		106,432	Health Care Worker Background Check	1,607
				Employee Health Insurance		85,234	(Indicate # of checks performed)	
				Employee Meals		0	MARKETING/ADV/PROMO	22,116
				Illinois Municipal Retirement Fund (IMRF)*			RELATED PARTY	264
				EMPLOYEE BENEFITS - OTHER		1,269	CONTRIBUTIONS	650
				EMPLOYEE PHYSICAL EXAMS		1,758	DUES & SUBSCRIPTIONS	6,507
				PENSION/PROFIT SHARING PLANS		8,953	LICENSES & PERMITS	615
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	POLITICAL CONTRIBUTIONS	(650)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(22,116)
	Description		Amount				Yellow page advertising	(0)
	ASTA HEALTH CARE COMPANY - MNGMT FEE		\$ 180,407					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$	242,474	TOTAL (agree to Sch. V,	\$ 11,015
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
				to Owners or Employees				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
ENLOE	DATA PROCESSING		\$ 1,950				Out-of-State Travel	\$
HEALTH DATA SYSTEMS	DATA PROCESSING		3,697					
ASTA HEALTHCARE	DATA PROCESSING		92					
AMERICAN HEALTHCARE	DATA PROCESSING		1,530				In-State Travel	
KRUPNICK BOKOR	ACCOUNTING		2,900					0
AZULAY, HORN	LEGAL		1,627					
STONE MCGUIRE	LEGAL		3,771					
PERSONNEL PLANNERS	UNEMPLOYMENT		577				Seminar Expense	
								5,698
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$2500 attach copy of invoices.)							(agree to Sch. V,	
			\$ 16,144				line 24, col. 8)	\$ 5,698

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	6/99	\$ 3,292	3	\$	\$ 549	\$ 1,097	\$ 1,097	\$ 549	\$	\$	\$	\$
2	PAINT/DECORATING	6/00	6,245	3			1,041	2,082	2,082	1,040			
3	PAINT/DECORATING	6/01	869	3				145	290	290	144		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 10,406		\$	\$ 549	\$ 2,138	\$ 3,324	\$ 2,921	\$ 1,330	\$ 144	\$	\$

Facility Name & ID Number ASTA CARE CENTER OF TOLUCA

0042796

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC. \$ 5565
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,612 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 56,940
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,565
	REPAIRS & MAINTENANCE	1,168
		0
		6,733
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	619
		0
		619
5	HEAT & OTHER UTILITIES	
	GAS HEAT	10,587
	ELECTRICITY	42,579
	WATER	20,179
	CABLE TV - LOBBY	0
		0
		73,345
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,562
	PAINTING & DECORATING	869
	BUILDING REPAIRS	1,012
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,212
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,002
	FIRE SERVICE	3,226
	CONTRACTED BUILDING MAINTENANCE	500
		0
		0
		16,383
7	OTHER	
	SCAVENGER	3,442
	SECURITY SERVICE	0
		3,442
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	7,200
		7,200

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	640
	PHARMACY CONSULTANT XVIII B 39-2	936
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
	PROGRAM CONSULTANT	4,438
	DENTAL CONSULTANT	3,186
		9,200
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	944
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		944
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,023
		0
		1,023
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	5,174
		0
		5,174
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B180,407	180,407
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C7,269	
	ADMINISTRATIVE CONSULTANTS	XIX C0	
	PROFESSIONAL FEES	XIX C8,875	
		0	16,144
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F22,116	
	EMPLOYEE WANT ADS	XIX F2,022	
	CONTRIBUTIONS	VI 20 XIX F450	
	DUES & SUBSCRIPTIONS	XIX F6,507	
	LICENSES & PERMITS	XIX F615	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F200	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F1,607	33,517
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES	446	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 180	
	HOME OFFICE EXPENSE	11,100	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	14,829	
	MESSENGER SERVICE	323	
	CABLE T.V.	1,685	28,383

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D106,432	
	UNEMPLOYMENT COMPENSATION	XIX D9,008	
	WORKERS COMPENSATION INSURANC	XIX D29,820	
	HOSPITALIZATION INSURANCE	XIX D85,234	
	EMPLOYEE BENEFITS - OTHER	XIX D1,269	
	EMPLOYEE PHYSICAL EXAMS	XIX D1,758	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D0	
	PENSION/PROFIT SHARING PLANS	XIX D8,953	
	CHICAGO HEAD TAX	XIX D0	242,474
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	4,318	4,318
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G0	
	TRAVEL	XIX G0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	4,742	4,742
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	47,321	47,321
27	OTHER		
	BAD DEBTS	VI 2418,739	
		0	18,739

GRAND TOTAL COLUMN 3 OTHER

700,108

ASTA CARE CENTER OF TOLUCA
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	126,322	PATIENT MEALS	80343
LESS SALES TAX	635	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	125687	TOTAL MEALS/YEAR	80343
TOTAL PATIENT CENSUS	26,781	NET FOOD	125687
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	80343

TOTAL PATIENT MEALS	80343	COST PER MEAL	1.56
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		